H.R.S.A. Planning Grants
Interim Report

Idaho State Planning Grant
October 25, 2001

In March of 2001, the state of Idaho was one of nine states awarded a one-year State Planning Grant to develop plans for providing health insurance to its uninsured residents. The amount of Idaho's award was $1.19 million dollars, and the Department of Commerce was designated the official state administrative agency for the grant. Under the program, administered nationally by HHS' Health Resources and Services Administration, studies were to be conducted to identify characteristics of Idaho's uninsured population. Data results were then to be utilized to determine the most effective methods to provide uninsured Idahoans with high-quality, affordable health insurance. Eleven states were given similar awards in the fall of 2000.

This interim report describes the results of the first six months of the funding period. During that time, data on the uninsured were collected and analyzed, and policies to cover the uninsured were researched and presented. Researchers from Boise State University's Center for Health Policy led both the data team and the policy team in these endeavors. The teams were comprised of individuals from around the state representing a cross-section of state agencies, private and public nonprofit groups, the health insurance sector, business and industry, minority populations, universities, and health care delivery professionals.

The purpose of the data team was to collect and analyze qualitative and quantitative data to describe the uninsured in Idaho and to determine reasons why that group might not have health insurance. Beginning in early April, the data team met on a regular basis to develop plans to identify existing data sets that could be used to describe the uninsured, to identify gaps in the data, to distribute the tasks to carry out the necessary work to collect missing data, and to assess the progress of data collection and analysis efforts. The final data report was presented in August.

The purpose of the policy team was to investigate all possible policy options that would provide coverage to the uninsured. After an initial meeting in late April, the policy team met once or twice per month from June through mid-September to learn about existing state and federal policies to provide coverage for the uninsured, to develop a plan to identify coverage options used by other states, to study those plans, and to postulate possible coverage approaches that might be unique to Idaho. Because one of the goals of the project was to find a method to cover every uninsured Idahoan, an effort was also made to construct combination approaches that, if implemented, might allow Idaho to realize that goal. Mechanisms for funding of the possible options were included in the policy analysis.

SECTION 1. SUMMARY OF FINDINGS: UNINSURED INDIVIDUALS AND FAMILIES

Quantitative data describing the uninsured in Idaho were available from the Current Population Survey (CPS) and the Idaho Behavioral Risk Factor Surveillance System (BRFSS). Qualitative data were collected using focus groups.

1.1 *What is the overall level of uninsurance in your State?*

Approximately 18%, or 200,000 – 240,000 Idahoans lack health insurance (1997-1999 CPS, 2000 BRFSS). Based on recent population growth rates in Idaho, there are about 635 new Idahoans without health insurance every month.

Population Distribution by Insurance Status in Idaho and U.S.

Insurance Status	Percent, Idaho*	Percent, US*
Employer	56%	58%
Individual	7%	5%
Medicaid	8%	10%
Medicare	11%	11%
Uninsured	**18%**	**16%**
Total	100%	100%

* Results from 1997-1999 CPS.

1.2 *What are the characteristics of the uninsured?*

There are several factors relating to being uninsured in Idaho, including age, income, and employment status.

Table of Uninsured Idahoans by Age

Age Group	Percent Who Are Uninsured*	Number Uninsured**
<18	13-19%	47,000-72,000
18-24	29.1	33,500
25-34	22.4	35,700
35-44	18.5	33,600
45-54	17.2	28,600
55-64	16.6	18,150
65+	1.6	2,500

* Adult results from 2000 Idaho BRFSS; <18 results from BRFSS and CPS.
** For 18+, estimates are based upon Claritas population estimates. Official 2000 Census population figures are approximately 3.8% higher; current 2001 estimates are not yet available.

Table of Uninsured Idahoans (18-64) by Income

Income	Percent Who Are Uninsured*	Number Uninsured**	Percent Of All Uninsured*
< $15,000	39.6%	28,830	19.2%
$15,000 - $24,999	43.6%	61,870	41.2%
$25,000 - $34,999	19.8%	26,580	17.7%
$35,000 - $49,999	13.9%	24,030	16.0%
$50,000 +	4.0%	8,860	5.9%

* Results from 2000 Idaho BRFSS.

** Estimates based upon Claritas population estimates. Official 2000 Census population figures are approximately 3.8% higher; current 2001 estimates are not yet available.

Table of Uninsured Idahoans (0-64) by Income as FPG%

	Household Income as Federal Poverty Guidelines Percent*				
Uninsured Population	<= 100%	101-150%	151-200%	201% +	Total
Children aged < 18**					
Number Uninsured	17,050	11,740	9,230	10,300	48,310
Percent	35.3%	24.3%	19.1%	21.3%	100%
Adults 18-64***					
Number Uninsured	45,420	24,590	26,060	52,850	148,920
Percent	30.5%	16.5%	17.5%	35.5%	100%
Adults with Children in Household***					
Number Uninsured	31,440	16,110	16,160	18,510	82,220
Adults w/ no Children in Household***					
Number Uninsured	13,970	8,500	9,900	34,310	66,700
Percent	21.0%	12.8%	14.9%	51.5%	100%

* Results from 2000 Idaho BRFSS; FPG% estimated based upon income categories.

** Estimate based upon Official 2000 Census population. Rounded to nearest 10.

*** Estimates based upon Claritas population estimates. Official 2000 Census population figures are approximately 3.8% higher; current 2001 estimates are not yet available.

Table of Uninsured Idahoans (18-64) by Employment Status

Employment Status	Percent Who Are Uninsured*	Number Uninsured**	Percent Of All Uninsured*
Employed for wages	16.3%	77,030	51.3%
Self-employed	34.8%	30,180	20.1%
Unemployed	51.1%	15,920	10.6%
Homemaker	18.5%	10,960	7.3%
Student	20.1%	6,160	4.1%
Retired	13.8%	3,900	2.6%
Unable to work	21.6%	6,010	4.0%

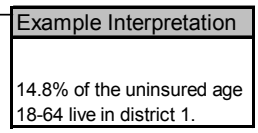
* Results from 2000 Idaho BRFSS.

** Estimates based upon Claritas population estimates. Official 2000 Census population figures are approximately 3.8% higher; current 2001 estimates are not yet available.

These results show that over 70% of Idaho's uninsured adults (18-64) are employed or self-employed, and about 80% of Idaho's uninsured adults are in working families.

Descriptions of the Idaho insured and uninsured populations (adults age 18 to 64), 2000 (percent)

	Insured	Uninsured
n=	*3314*	*848*
DISTRICT		
District 1	14.0	14.8
District 2	8.4	7.8
District 3	13.6	17.4
District 4	28.6	23.1
District 5	11.3	14.9
District 6	12.1	10.0
District 7	12.0	12.0
SEX		
Male	49.9	51.1
Female	50.1	48.9
AGE		
18-24	13.7	22.0
25-34	21.3	24.0
35-44	25.6	22.6
45-54	23.8	19.3
55-64	15.7	12.2
SEX AND AGE		
MALE		
18-34	35.0	49.3
35-54	49.2	40.4
55+	15.8	10.3
FEMALE		
18-34	35.1	42.5
35-54	49.4	43.3
55+	15.5	14.2
INCOME		
< $15,000	7.5	19.2
$15-$24,999	13.5	41.2
$25-$34,999	18.1	17.7
$35-$49,999	25.2	16.0
$50,000+	35.8	5.9
EDUCATION		
K-11	5.8	16.1
High School Graduate	28.9	42.8
Some College	34.8	30.5
College Graduate	30.6	10.6



NOTE:

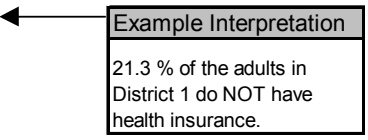
The Idaho Behavioral Risk Factor Surveillance System (BRFSS) is a random telephone survey of Idaho adults aged 18 and older. Don't know, not sure, and refused responses have been excluded from the analysis.

Descriptions of the Idaho insured and uninsured populations (adults age 18 to 64), 2000 (Percent)

	Insured	Uninsured
n=	*3314*	*848*
EMPLOYMENT		
Employed for Wages	67.5	51.3
Self Employed	9.6	20.1
Unemployed	2.6	10.6
Homemaker	8.2	7.3
Student	4.2	4.1
Retired	4.2	2.6
Unable to work	3.7	4.0
ETHNICITY		
Hispanic	4.6	9.3
Non-Hispanic	95.5	90.7
POPULATION DENSITY		
Urban	66.3	57.9
Rural	24.9	31.0
Frontier	8.8	11.1

Idaho adults age 18 to 64 who do NOT have health care coverage, 2000 (percent)

	N	Percent
TOTAL	4162	20.4
DISTRICT		
District 1	592	21.3
District 2	586	19.2
District 3	583	24.6
District 4	642	17.1
District 5	581	25.3
District 6	586	17.5
District 7	592	20.4
SEX		
Male	1803	20.8
Female	2359	20.0
AGE		
18-24	568	29.1
25-34	930	22.4
35-44	1110	18.5
45-54	940	17.2
55-64	614	16.6
SEX AND AGE		
MALE		
18-34	633	26.9
35-54	916	17.7
55+	254	14.6
FEMALE		
18-34	865	23.3
35-54	1134	18.0
55+	360	18.6
INCOME		
< $15,000	456	39.6
$15-$24,999	793	43.6
$25-$34,999	710	19.8
$35-$49,999	884	13.9
$50,000+	1063	4.0
EDUCATION		
K-11	323	41.7
High School Graduate	1317	27.6
Some College	1409	18.4
College Graduate	1108	8.2



NOTE:

The Idaho Behavioral Risk Factor Surveillance System (BRFSS) is a random telephone survey of Idaho adults aged 18 and older. Don't know, not sure, and refused responses have been excluded from the analysis.

Idaho adults age 18 through 64 who do NOT have health care coverage, 2000 data (percent)

	N	Percent
EMPLOYMENT		
Employed for Wages	2633	16.3
Self Employed	511	34.8
Unemployed	165	51.1
Homemaker	353	18.5
Student	168	20.1
Retired	157	13.8
Unable to work	168	21.6
ETHNICITY		
Hispanic	225	34.2
Non-Hispanic	3916	19.6
POPULATION DENSITY		
Urban	429	18.3
Rural	1158	24.1
Frontier	2552	24.5

1.3 *Summarizing the information provided above, what population groupings were particularly important for your state in developing targeted coverage expansion options?*

Low-income children – 38,020 children under age 18 in families with incomes less than 200% of the FPL were uninsured. This group accounts for 16% – 19% of Idaho's uninsured population.

Low-income working adults – Over 70% of Idaho's uninsured adults (18-64) are employed or self-employed, and when homemakers are included in these totals, about 80% of Idaho's uninsured adults come from working families. Sixty-four percent of Idaho's uninsured adults have family incomes below 200% of the FPL.

Low-income employees of small business – Fewer than 30% of employers with 0-5 FTE offered health insurance, while only 66% of those with 6-10 FTE offered health benefits. Likewise, businesses where the average annual salary was below $25,000 were much less likely to offer benefits than those with higher average salaries.

1.4 *What is affordable coverage?*

Focus groups and conversational interviews were conducted with several types of audiences: uninsured Idahoans who reside in rural areas, uninsured Idahoans residing in urban areas, agricultural employers (potato, sugar beet, and dairy farmers), insured and uninsured Hispanic residents, and employees of small businesses who do not offer health insurance. For most of the individuals interviewed, affordable coverage meant having premiums costing no more than $50-

100 per month (although individuals with no dependents might be willing to pay up to $200/month if the coverage was extensive). Several individuals noted that they would only pay that amount if the coverage was comprehensive (including prescription drugs and dental) and included the spouse. There were also some who could not afford coverage at any price.

1.5 *Why do uninsured individuals and families not participate in public programs for which they are eligible?*

The major reasons people do not access coverage when they are eligible are:

- they are unaware of their eligibility
- they are not fond of government programs (although they were generally very supportive of the CHIP program for their children). Of note is the fact that a substantial number did feel that *portability* is an advantage to a government-sponsored program.
- there are no medical providers in their area so having insurance is not worth the trouble
- the paperwork to become eligible seems onerous.

1.6 *Why do uninsured individuals and families disenroll from public programs?*

This question was not addressed.

1.7 *Why do uninsured individuals and families not participate in employer-sponsored coverage for which they are eligible?*

Some employees without dependents felt that they would not meet the deductible so they were willing to keep the dollars that would go to their portion of the premium and take the risk. Others had coverage with a spouse, had such low salaries that they cannot afford the premium, the coverage package was not "benefit rich" enough, or the coverage was too expensive when dependents are added (and they were not willing to insure only themselves).

1.8 *Do workers want their employers to play a role in providing insurance or would some other method be preferable?*

Many workers interviewed in Idaho feel that health coverage is the employer's responsibility. Employees of small business did recognize, however, that small employers had little ability to afford employee coverage. Workers with children covered under the CHIP program have been very pleased with the program and so have a favorable view of government programs Those concerned that an employer-sponsored system creates a product that is less portable if changing jobs tend to favor a government system.

1.9 *How likely are individuals to be influenced by: Availability of subsidies? Tax credits or other incentives?*

This question was not addressed.

1.10 *What other barriers besides affordability prevent the purchase of health insurance?*

While affordability is the major factor cited by both employers and employees for not offering or purchasing health insurance, other factors include: the nature of the benefit package, lack of coverage for pre-existing conditions, the hassle of paperwork, no portability, lack of access to health care providers, insurance plans are confusing (there are so many types of policies and coverage options that it is impossible to know what is really covered and what is not covered), and some individuals feel that they just are not going to get sick.

1.11 *How are the uninsured getting their medical needs met?*

There is a persistent misconception that people who do not have health insurance somehow get the care they need in Idaho, especially when they have serious health problems. In fact, the uninsured have numerous problems getting care.

- Qualitative data collection through focus groups and structured interviews found that the average uninsured Idahoan has experienced problems accessing primary care, pharmacy, dental and eye care *(Evaluation of Uninsured Idahoans Focus Groups and Conversational Interviews, May-June, 2001)*.
- Most respondents said they just suffer through illnesses *(Small Business Employee Group Discussions, August, 2001*).
- Uninsured are grateful to the safety net clinics for providing access, but often don't have the resources to afford even the reduced fees of these clinics. Therefore, they postpone care, especially for chronic diseases (*Evaluation of Hispanic Focus Groups)*.
- The health care safety net in Idaho is comprised of six groups of Community/Migrant Health Centers with a combined count of 23 clinic sites including three Oregon locations serving Idaho patients. They are located primarily in the southern agricultural regions along the Snake River plain and on one Indian reservation in the north. In addition, two family practice residency clinics serve some uninsured in the two metropolitan communities of the state. Eight volunteer-run "free" clinics have been established in seven of Idaho's communities. Thirty-five clinics designated as Rural Health Clinics also provide some level of access to primary care for "self-pay" patients. Six tribal health clinics provide care for Idaho's Native American population.
- Non-profit and county-funded hospitals located in all but eight of Idaho's 44 counties provide emergency care and some non-emergent care for uninsured Idahoans.

1.12 *What is a minimum benefit?*

The definition of a minimum benefit depends upon who is defining the term "minimum". When asked simply to define the benefits they felt a package should include, focus group participants defined "minimum" in terms of a comprehensive plan with preventive care, vision, dental, emergency care, and prescription drug coverage, preferably with dependent coverage available. The planning grant study group developing the small business model (employee premium comes from a combination of employer, employee, and state-federal subsidy) used an actuary to

determine the benefit plan that could be afforded with a payment of $150 per month from a combination of the above three sources. The benefit design includes preventative and emergency care, in-patient and outpatient procedures, prescription drug coverage, and some mental health coverage. It is capped at $50,000 annually and requires some co-pays/deductibles. While this is not the plan outlined above as being most desirable, people responding favorably to both the price and the coverage outlined.

1.13 *How should underinsured be defined? How many of those defined as "insured" are underinsured?*

This question was not addressed.

SECTION 2. SUMMARY OF FINDINGS: EMPLOYER-BASED COVERAGE

Quantitative data on employer-based health insurance coverage were collected via Idaho's Employer Health Care Benefit Survey. This mail survey was designed as a stratified random sample of Idaho's businesses (excluding government agencies and most schools). A total of 3,647 usable questionnaires were returned, corresponding to a response rate of about 18%. Data were weighted by the inverse of the probability of selection and poststratified to the number of businesses in the sampling frame by county and size of business. Qualitative data on employer-based health insurance coverage were collected via focus groups.

2.1 *What are the characteristics of firms that do not offer coverage, as compared to firms that do?*

About half of respondents (48.5%) reported offering health benefits and/or a health plan to their employees. Whether or not a business offered health care coverage to its employees was statistically significantly related to several factors, including size of business, type of business, average annual salary of employees, perceived importance of health insurance to employees, and urban/rural/frontier county designation ($p < 0.0001$ for each; there were too few respondents in most counties to give county results). The relationships of health care coverage to these other factors are summarized in the tables below. Logistic regression was used to look at the variables predictive of offering health care benefits as a group; all variables above except the geographical variables (county and urban/rural/frontier county designation) were statistically significant independent predictors of offering health care coverage. These findings show that size of business, type of business, average annual salary of employees, and perceived importance of health insurance to employees are the critical factors in whether or not a business offers health care coverage to their employees.

Table of Health Care Coverage by Size of Business

Size of Business	Estimated Number of Businesses	Percent Offering Health Insurance
0- 5 FTE	27,212	29.9%
6- 10 FTE	7,332	66.3%
11- 15 FTE	2,306	75.3%
16- 20 FTE	1,379	83.8%
21- 30 FTE	1,899	84.4%
31- 50 FTE	1,371	90.7%
51-100 FTE	1,188	90.3%
101-250 FTE	884	98.3%
251+ FTE	644	95.1%

Weighted Frequency Missing = 7,565

Table of Health Care Coverage by Main Focus of Business

Main Focus of Business	Estimated Number of Businesses	Percent Offering Health Insurance
Aviation/transportation	948	49.4%
Construction	4,412	43.4%
Financial/banking	2,055	61.0%
Health care	4,755	61.6%
Law	1,251	61.0%
Manufacturing	2,540	63.4%
Retail	8,117	46.1%
Services	8,033	33.9%
Wholesale	1,004	70.4%
Other	7,986	46.7%

Weighted Frequency Missing = 7,589

Note: Other categories had too few respondents for valid statistics (<60).

Table of Health Care Coverage by Average Salary

Average Annual Salary of Employees	Estimated Number of Businesses	Percent Offering Health Insurance
Below $10,000	7,288	10.5%
$10,000-14,999	4,806	23.1%
$15,000-19,999	6,725	43.9%
$20,000-24,999	8,108	58.9%
$25,000-29,999	7,167	73.1%
$30,000-34,999	4,294	80.3%
$35,000-39,999	1,861	67.6%
$40,000 or more	2,855	60.7%

Weighted Frequency Missing = 8,676

Table of Health Care Coverage by Company Operations

Area of Company Operations	Estimated Number of Businesses	Percent Offering Health Insurance
Idaho only	35,061	45.2%
Multi-state	9,203	58.9%
International	965	75.5%

Weighted Frequency Missing = 6,552

Table of Health Care Coverage by Perceived Importance of Health Insurance

Perceived Importance of Health Insurance	Estimated Number of Businesses	Percent Offering Health Insurance
Very Important	27,384	61.7
Important	10,604	40.1
Somewhat Important	3,971	18.2
Not At All	1,840	1.1

Weighted Frequency Missing = 7,981

Table of Health Care Coverage by Urban/Rural/Frontier County Designation

County Designation	Estimated Number of Businesses	Percent Offering Health Insurance
Frontier	6,681	39.1%
Rural	10,641	42.3%
Urban	28,561	53.1%

Weighted Frequency Missing = 5,897

Estimated Numbers of Businesses and Employees Eligible for Proposed Model Programs

Numbers of businesses and employees eligible for potential programs were estimated using these survey data. Businesses with no reported current health care coverage for employees and average annual salaries below $20,000 and below $25,000 were selected, and a table (see below) was created by size of business. If only respondents who regard health insurance to be important or very important to their employees are considered, the estimates below drop by about one-third.

Eligible for Proposed Model Programs

Size of Business	Average Salary < $20,000		Average Salary < $25,000	
	Estimated Number of Eligible Businesses	Estimated Number of Employees in Eligible Businesses	Estimated Number of Eligible Businesses	Estimated Number of Employees in Eligible Businesses
0- 5 FTE	11,284	24,648	13,828	31,395
6- 10 FTE	1,529	11,215	1,941	14,164
11- 15 FTE	376	4,772	486	6,156
16- 20 FTE	95	1,596	181	3,045

Note: Due to missing data, these are likely underestimates by up to 20%.

Results from employers offering coverage:

Increases in Health Care Rates

The median increase in health care rates in 2000 was 16%, ranging from about zero to over 250%. Ninety percent of businesses had rate increases of 5% or greater in 2000, and ten percent of businesses had rate increases of 30% or greater. The median increase (actual or expected) in health care rates in 2001 was 14%, ranging again from about zero to over 250%. Ninety percent of businesses had rate increases of 2% or greater in 2001, and again ten percent of businesses had rate increases of 30% or greater. Businesses have used several mechanisms to cope with rate increases in the past two years (see table below).

Rate Increases Have Caused Businesses to:

Coping Mechanism	Percent
Move to a different carrier or network	29.6%
Change plan funding	9.5%
Drop health care benefits	8.0%
Increase employee contributions	21.2%
Change benefit plan design	39.2%

Note: Multiple responses were allowed.

Health Care Plan Eligibility and Costs

Most businesses (84.8%) covered full-time employees with their health care plan, 13.8% covered part-time employees, and 3.4% covered seasonal employees. Among the full-time employees covered, all eligible employees participate in 55% of businesses, and two-thirds or more of eligible employees participate in 80% of businesses. Among the part-time employees covered, all eligible employees participate in 30% of businesses, and no eligible employees participate in about 30% of businesses. Among the seasonal employees covered, all eligible employees participate in about 20% of businesses, and no eligible employees participate in about 40% of businesses.

The median cost per employee per month for total health care coverage was about $225. Median costs per employee per month did not differ substantially by size of business, ranging from $200 - $240 per month. There was no pattern or trend in terms of cost by size of business. Median costs per employee were in the range of $200 - $250 per month regardless of whether the health care benefits were fully or self-insured or how they were structured. Currently, about 37% of businesses spend more than 10% of their total budgeted payroll on health care; fewer than 15% of businesses think it is reasonable to spend this much (see table below).

Percent of Total Budgeted Payroll Spent on Health Care

Percent of Total Budgeted Payroll	Actual Amount Spent Per Year (% of Respondents)	Believe is Reasonable Amount to Spend (% of Respondents)
Less than 5%	23.7%	41.4%
6% - 10%	39.1%	44.4%
11% - 15%	20.0%	9.9%
16% - 20%	9.9%	3.5%
More than 20%	7.2%	0.8%

Approximately 80% of businesses pay 2/3 or more of employee premiums for health care coverage, and about 65% of businesses pay 100% of employee premiums. Only 2.5% of businesses offer a sliding scale contribution, such that the employer pays more for lower-wage workers than for higher-wage workers. Eighty-eight percent of businesses allow dependents of eligible employees to participate in their health care plan. Some employees don't enroll their dependents. The number one reason given is that dependents are covered under another plan (48.9%), and the number two reason is that dependent coverage is too expensive (43.3%).

2.2 *What influences the employer's decision about whether or not to offer coverage?*

About two-thirds (67.6%) of businesses make health benefit decisions at their location, 9.8% do not, and 22.7% marked "not applicable". Among those not making health benefit decisions at their location, 50.7% of companies permit input or recommendations from local managers.

The table below shows sources relied upon for employee benefit decisions. The instructions were to mark all that apply, so percents sum to more than 100%. Respondents wrote in to specify the "other" category; the most common responses were boards of directors, insurance agents, administrators, and brokers, as well as employee needs and requests.

Sources for Employee Benefit Decisions

Your plan's specific data	28.0%
Industry information	17.4%
Consultants	17.3%
Human resources staff	13.1%
Corporate headquarters	10.7%
Association resources	8.8%
Seminars	3.6%
National media	3.2%
Trade press	2.8%
Other	16.7%

What are the primary reasons that employers give for electing not to provide coverage? Respondents not currently offering health benefits to their employees were given several reasons to check for not offering health insurance. By far the most common answer was "too expensive" (60.4%; see table below). Respondents were directed to specify the "other" category. The most frequent comments were that business are too small or new, they cannot afford health insurance, employees are covered under other plans, and there are no other regular employees besides themselves.

Reasons For Not Offering Health Insurance

Reason Marked	Percent
Too expensive	60.4%
Too complex	10.6%
Afraid premiums will increase	11.2%
Afraid business will decline	4.2%
My employees are not interested	5.4%
I don't feel it is the employer's role to provide insurance	0.0%
It is unnecessary because my employees have other insurance	18.3%
Other	16.0%

Note: Percents do not sum to 100% because multiple responses were allowed.

Respondents who don't provide insurance because it is too expensive were asked what is the most they would pay for the employer portion of a health plan that covered only the employee. The median response was $26-50 per employee per month (see table below). Fewer than 2% of respondents state that they would pay the average premium (about $200) paid by businesses that do currently offer health insurance to employees.

Most Business Would Pay for Employer Portion of Health Plan

Coping Mechanism	Percent
I would not pay	17.1%
Up to $25 per employee per month	21.2%
$26-50 per employee per month	27.6%
$51-100 per employee per month	22.3%
$101-150 per employee per month	7.4%
$151-200 per employee per month	2.6%
Over $200 per employee per month	<2.0%

2.3 *What criteria do offering employers use to define benefit and premium participation levels?*

Our survey did not ask this question directly; however, respondents were asked to rate six factors in terms of importance in purchasing health care benefits. The ratings were converted to points, with the highest ranking among the factors assigned to the factor receiving the most points. The table below shows the results of the ratings, with "1" being the most important factor (most points). The most important factor, price of coverage, received only slightly more points than did the number two priority concern. Few respondents wrote in to specify the "other" category.

Rankings of Top Employee Benefit Concerns

Price of Coverage	1
Benefit Coverage	2
Customer Service	3
Size of Provider Network	4
Number of Available Plan Options	5
Other	6

2.4 *What would be the likely response of employers to an economic downturn or continued increases in costs?*

Approximately 41% of Idaho employers offering health insurance believe that up to 5% of their payroll is a reasonable amount to pay for health care, while another 44% feel that up to 10% is a reasonable figure. Focus groups of agricultural employers found that the large increases in premiums might result in losing the farm if a catastrophic health event took place in their family (most could not afford to offer employee coverage as it is). It is logical to conclude that an economic downturn or continued increases in costs will force some of the employers to raise the deductibles in plans offered to employees or to shift the costs to employees. More large companies might go to self-insurance. Some employers mentioned that going to defined contributions or contributing to medical savings accounts might also be a possibility if health insurance premium costs continue to rise.

2.5 *What employer and employee groups are most susceptible to crowd-out?*

This question was not addressed.

2.6 *How likely are employers who do not offer coverage to be influenced by: Expansion/development of purchasing alliances? Individual or employer subsidies? Additional tax incentives?*

This question was not addressed.

2.7 *What other alternatives might be available to motivate employers not now providing or contributing to coverage?*

Possibilities include setting up an insurance purchasing pool for all small businesses that can't afford to provide coverage alone, subsidizing employer premiums with a state or federal match, and allowing businesses to pay to have their employees enroll in the state employee health insurance system (particularly if subsidized).

SECTION 3. SUMMARY OF FINDINGS: HEALTH CARE MARKETPLACE

3.1 *How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How did you define adequate?*

This question was not addressed.

3.2 *What is the variation in benefits among non-group, small group, large group and self-insured plans?*

Idaho Insurance Data

The purpose of collecting this segment of data was to summarize aspects of the health insurance products that are currently available in Idaho. Data were requested from major insurance providers around the state in March 2001. Data sets were received from Blue Cross of Idaho and Regence Blue Shield of Idaho. Data shows that these two major companies cover nearly 50% of Idahoans. Bechtel Bettis, Inc. sent a faxed description of their coverage.

	Blue Cross		Regence		Total	
Type of Coverage	N	Percent	N	Percent	N	Percent
Group PPO	51,998	37.0	240	.1	52,238	13.9
Group Traditional	44,004	31.4	175,129	74.1	219,133	58.2
Individual PPO	3,679	2.6	0	0	3,679	1.0
Ind. Traditional	14,019	10.0	40,677	17.2	54,696	14.5
Group HMO	11,153	7.9	6	.0	11,159	3.0
Medicare Supp	15,465	11.0	20,238	8.6	35,703	9.5
Total Known	140,318	100.0	236,290	100.0	376,608	100.0
Missing	29	.0	5,616	2.3	5,645	1.5
Total Incld. Missing	140,347	100.0	241,906	100.0	38,2253	100.0

Blue Cross and Regence offer many different types of insurance products, which are grouped into the following types: Group PPO (Preferred Provider Organization), Group Traditional, Individual PPO (< age 65 only), Individual Traditional (< age 65 only), Group HMO, and Medicare Supplement. Chart 1 shows the number of subscribers having each type of coverage. A "subscriber" is an employee who has enrolled in a plan, excluding dependents or other family members who may be covered under the employee's plan. In the dataset used for these tables, Blue Cross has 140,347 total subscribers, of whom 128,083 (91%) live in Idaho, and Regence has 241,906 subscribers, of whom 222,503 (92%) live in Idaho. Within Blue Cross, most of these have either Group PPO (51,998 subscribers, or 37%) or Group Traditional (44,004 subscribers, or 31%), while in Regence most have Group Traditional (175,129 or 74%). In the charts by Type of Coverage, those living outside of Idaho and those with Medicare Supplemental are excluded.

Chart 1: Types of Coverage, by Insurance Carrier

Idaho Residents Only

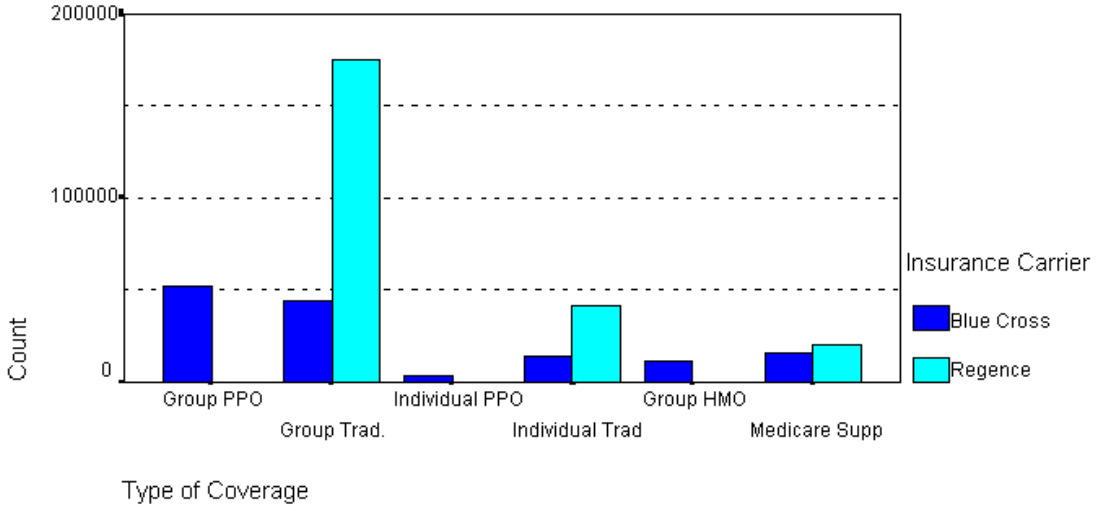


Chart 2: Size of Insured Groups

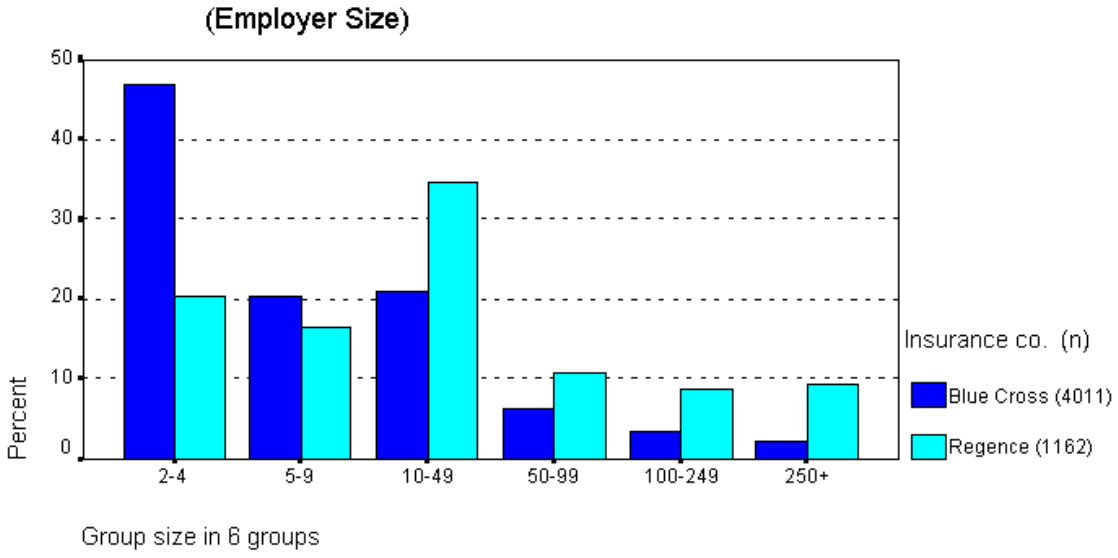
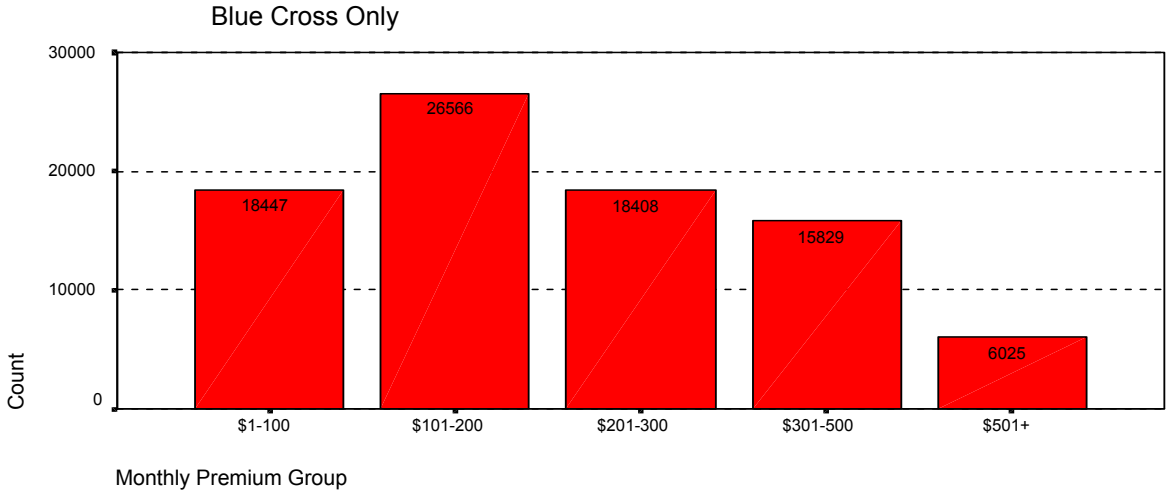


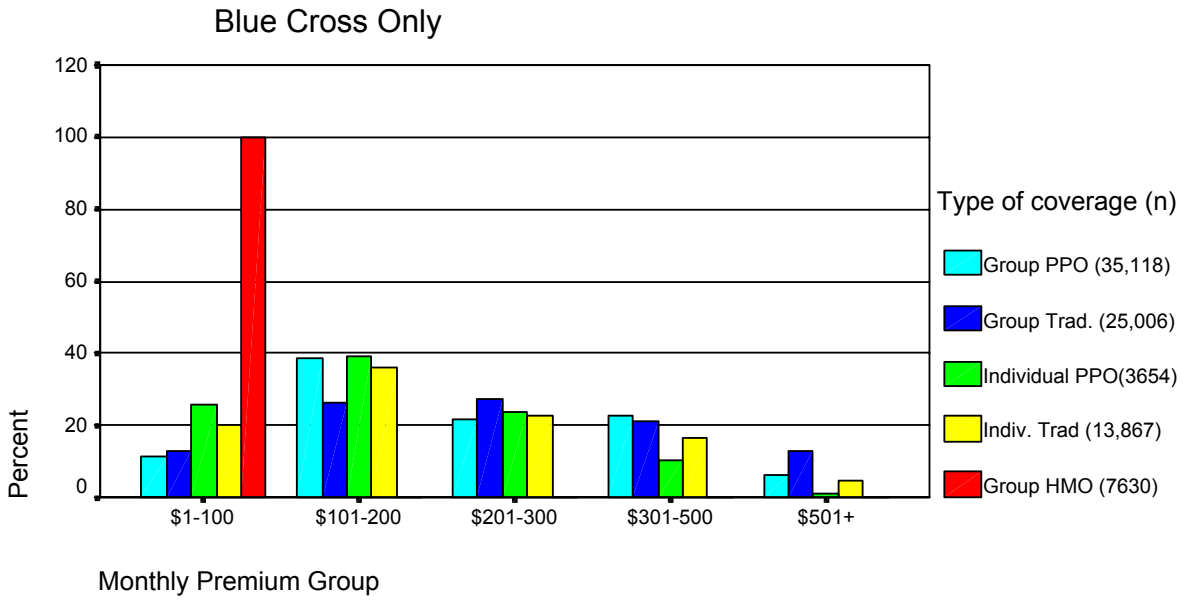
Chart 3: Monthly Premiums



Premiums

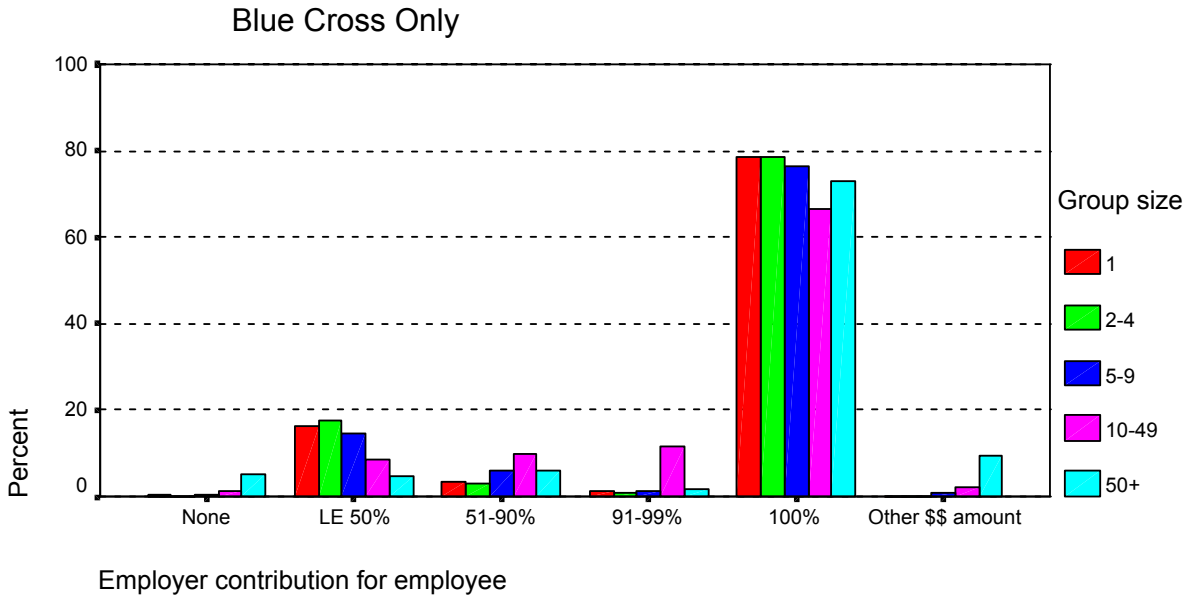
"Copays" refers to a fixed fee that the insured pays when using healthcare services. These data include data from Blue Cross only, as the Regence data that were received did not fit into this format. Blue Cross Premiums range from $1 to $1200 per month, per subscriber. The premium paid by the employee includes coverage for family members, if they are included on the policy. Chart 4 shows the premium amount by the type of coverage, as a percent. For example, among all subscribers with Group Traditional coverage, about 12% have premiums in the $1-100 range, 25% have premiums between $101-200, another 25% have premiums between $201-300, 20% have premiums between $301-500, and 15% have premiums greater than $500 per month.

Chart 4: Premium by Type of Coverage



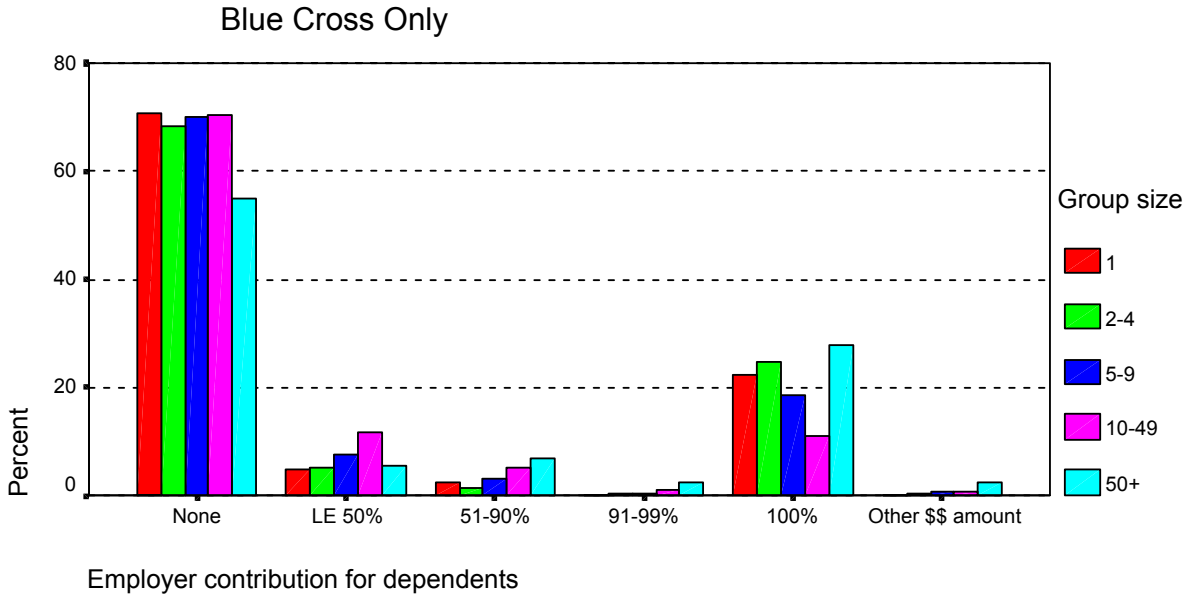
Employer contribution to employee premiums by group size is shown in Charts 5-6. Between 67% and 79% of employers pay 100% of the employee's premium cost, with the highest percentage (79%) in the 2-4 group size, and the lowest percentage (67%) in the 10-49 group size. Those in the 10-49 group size are more likely to pay between 90-99% (11.5% of groups 10-49, vs. 1-2% among other groups). The proportion of employers paying at least 90% of the employee premium is nearly identical across group sizes, ranging from 75% of all groups 50 or larger to 79% of all groups of 1 or of 2-4. Note that the percent of employers contributing nothing to employee premiums is the largest among groups larger than 50 (5%), and negligible among the smaller groups.

Chart 5: Employer Contribution to Employee Premiums



Employer contribution to dependent premiums (Chart 6) is lower; most employers pay nothing toward dependent premiums (68% of all groups, ranging from 55% among groups larger than 50 to around 70% in all other groups). Employers who contribute any amount to dependent premiums tend to pay the entire premium (ranging from 28% of groups larger than 50 to 11% in groups 10-50).

Chart 6: Employer Contribution to Dependent Premiums



Deductibles (Chart 7) and Coinsurance (Chart 8)

Deductibles tend to be higher in individual policies than in group policies. "Coinsurance" refers to the proportion of medical costs paid by the insurance company, after deductibles are met. This is usually in the 70%-90% range, although in PPO plans it is often 50% for healthcare from providers outside the PPO network. For Group Traditional and Individual PPO plans, 80% coinsurance is most common, while most Group PPO plans have coinsurance between 85-100% (for care received within the PPO network). Individual traditional plans, which tend to have high deductible (see Chart 7), also tend to have coinsurance between 85-100%.

Chart 7: Deductibles by Type of Coverage

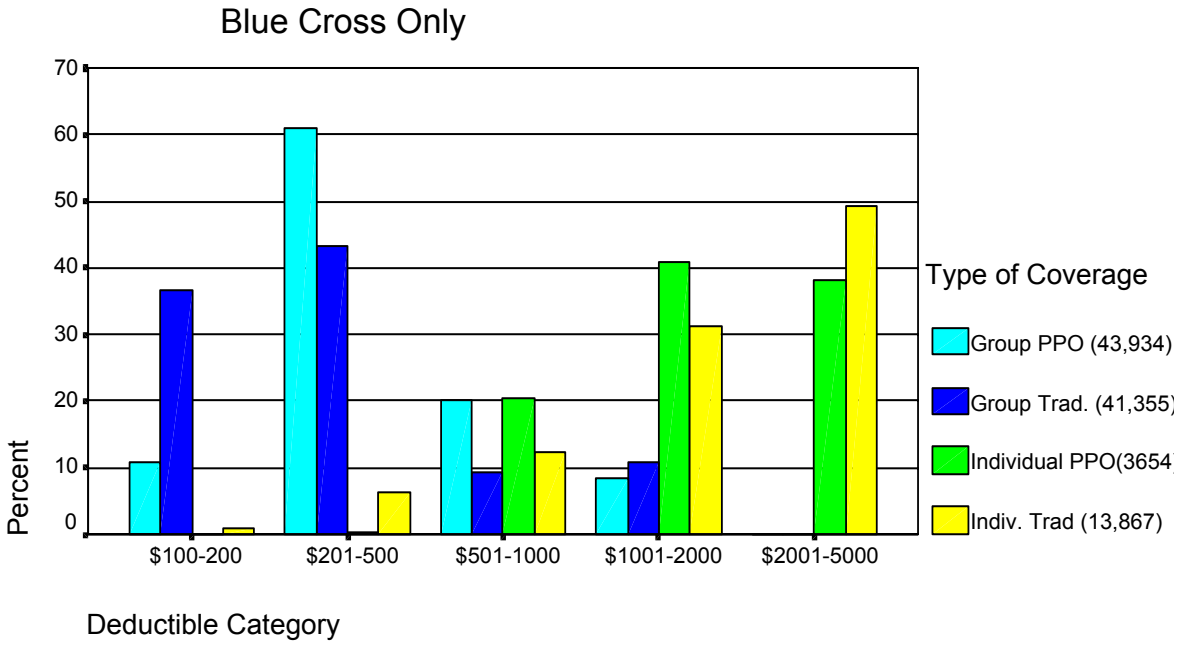
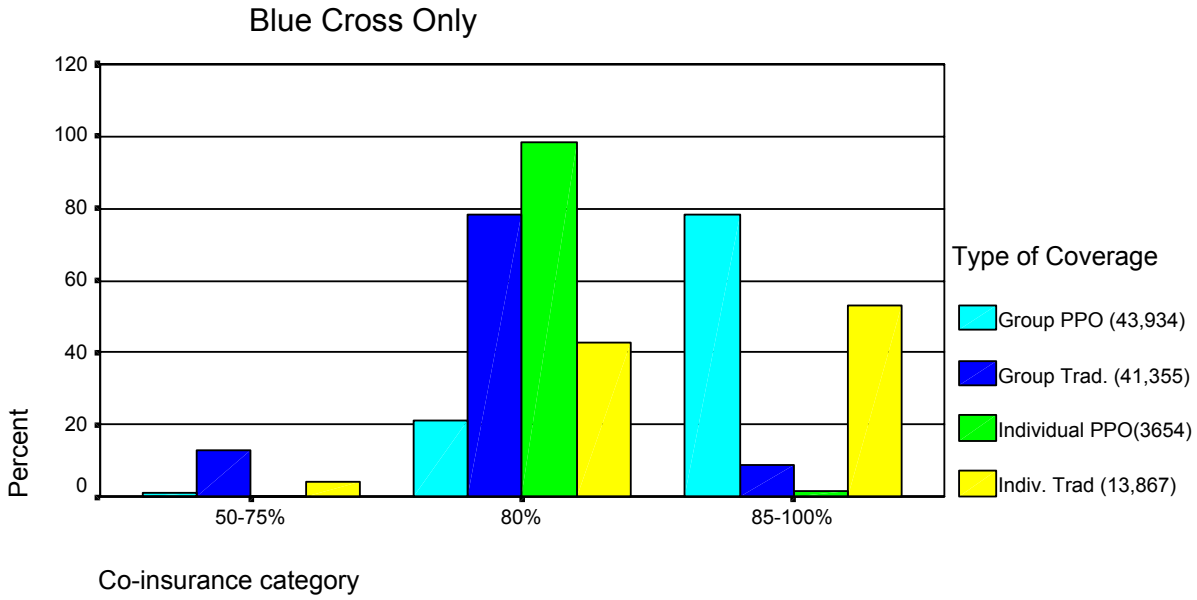


Chart 8: Co-insurance level by Type of Coverage



Prescription Drug Benefits: Copays and Coinsurance

Prescription drugs often have a copay amount, which again differs by type of coverage. "Copay" refers to a fixed fee that the insured pays when purchasing prescription drugs or other healthcare services. Low copays of $5 are found in Individual Traditional plans, intermediate copays of $10 are most often found in Group PPO and Group Traditional plans, and higher copays of $11-20 are found in Group HMOs. Coinsurance for prescription drugs is most commonly 80% for Group Traditional and Individual PPO plans, while higher coinsurance for drugs is found in Group PPO and Individual Traditional plans.

3.3 *How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?*

Nearly 12% of employer respondents to the Employer Health Care Benefit Survey reported that they were self-insured. However, because these employers tend to be the largest employers within the state, the number of people covered by these plans is substantial.

3.4 *What impact does your State have as a purchaser of health care (e.g. for Medicaid, SCHIP and State employees)?*

This question was not addressed.

3.5 *What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?*

In Idaho, the current regulatory environment is not conducive to promoting models for universal coverage. The Idaho legislature is representative of the feelings of many in the state that whenever possible each individual should be self-reliant. Consequently, even with a federal-state match on Medicaid of 70-30 the state is reluctant to spend more money to cover low-income persons in the state. A federal regulatory environment that was open to allowing a waiver of Medicaid rules to reduce (possibly significantly) the benefit package and still receive the match might open up a Medicaid expansion and a CHIP expansion in Idaho that would allow for the majority of Idahoans without insurance to be covered.

3.6 *How would universal coverage affect the financial status of health plans and providers?*

This question was not addressed.

3.7 *How did the planning process take safety net providers into account?*

The Policy Team considered two options for expansion of health insurance coverage that would relieve a portion of the financial burden for providing care for the uninsured in Idaho. The first approach would expand Medicaid eligibility for adults with incomes up to 100% of the FPL through an income disregard combined with a waiver. The waiver would not only provide for coverage of childless adults, but would also limit the scope of benefits to a defined set of primary and preventive care services. By utilizing Medicaid, the approach would maximize federal matching funds. The second option considered providing for a primary and preventive care grant program funded solely by state funds that would give certain safety net providers a capped amount to serve uninsured patients.

3.8 *How would utilization change with universal coverage?*

This question was not addressed.

3.9 *Did you consider the experience of other States with regard to: Expansions of public coverage? Public/private partnerships? Incentives for employers to offer coverage? Regulation of the marketplace?*

Descriptive case studies were presented outlining approaches used by the following states to expand coverage: New York, Oregon, Rhode Island, and Wisconsin.

SECTION 4. OPTIONS FOR EXPANDING COVERAGE

We are currently at the stage of selecting options to expand coverage. A variety of options are being evaluated.

SECTION 5. CONSENSUS BUILDING STRATEGY

5.1 *What was the governance structure used in the planning process and how effective was it as a decision-making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?*

The Idaho Department of Commerce acts as the lead agency in implementing the Idaho State Planning Grant. The Department of Commerce established a Steering Committee, which has broad representation from the legislature, the state's universities, state agencies, medical institutions, private business, and community organizations. This committee meets every other month, and has provided strategic guidance to staff and various functional work groups.

A Leadership Team (composed of the project director and team leaders for project working groups) is responsible for ongoing project management. This team supervises the work of the project teams, focuses on policy issues, ensures ongoing coordination and communications, and defines the scope of each team project. The Leadership Team meets at least every two weeks.

Three functional work groups complete the Idaho State Planning Grant's governance structure: the Data and Policy, Model Development, and Strategic Planning work groups. Each of these groups has broad representation from key stakeholders in the issue this grant addresses: Idaho's uninsured. Influential legislators, managers of relevant state agencies, health care professionals, insurance industry executives, business leaders, university staff, and community leaders serve on each of the work groups. They have devoted countless hours to studying the issue, developing policy options, and evaluating the best options for meeting Idaho's needs.

The decision-making structure appears to be functioning effectively. The communication between each committee or team is effective in keeping all participants aware of the progress that is being made and focused on the objective of increasing access to health insurance to those currently uninsured.

5.2 *What methods were used to obtain input from the public and key constituencies (e.g., town hall meetings, policy forums, focus groups, or citizen surveys)?*

To date, the primary method of communicating with and obtaining input from the public and key constituencies has been presentations made by project staff. They have met with chambers of commerce throughout Idaho, key legislative committees, the Governor's health insurance advisors, industry groups, charitable organizations, county and city elected officials, county and city associations, and various interest and advocacy groups.

Seven community forums, in key regions throughout Idaho, are scheduled for the week of November 12 through 16, 2001. More than 1,000 business and community leaders are receiving invitations to these forums. The general public will also be invited through announcements in the media. At these forums, participants will have an opportunity to learn about the current situation of the uninsured in Idaho, hear proposed options for substantially reducing the number of uninsured, and register their opinions and preferences using e-voting technology - which allows instantaneous data collection and displaying of the results. Follow-up discussion will allow the grant team to identify areas of confusion or concern.

While traveling across the state to hold these community forums, the project team will meet with editorial boards and other news media whenever possible to generate wide public awareness of the project and its goal of reducing the number of uninsured in Idaho.

5.3 *What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?*

The public relations firm retained by the Idaho State Planning Grant has published a 22-page spiral-bound summary of the data on Idaho's uninsured: Idahoans *Without Health Insurance, A Data Report*. This summary report presents the facts in a straightforward yet compelling way - therefore laying a strong foundation for the action plan being prepared by the Strategic Planning team. The report will be distributed to approximately 1,500 people throughout Idaho.
This data summary, as well as the full data report, is accessible through a website: www.idahouninsured.org.

5.4 *How has this planning effort affected the policy environment? Describe the current policy environment in the State and the likelihood that the coverage expansion proposals will be undertaken in full.*

Activities undertaken by the Idaho State Planning Grant have generated much interest and support among Idaho's business leaders, which has resulted in greater interest among legislators than might otherwise have been the case. Legislators acknowledge that they have been studying this issue for years and yet politically feasible solutions have eluded them. The Grant has provided the means of increasing public awareness of the issue, particularly the impact the uninsured have on society at large. The growing support among business leaders, as well as community and advocacy groups, for developing an action plan to reduce the number of uninsured is likely to increase the desire among state government officials to act on this issue.
Though the public will for taking action is likely to increase, the fact remains that Idaho is - as is nearly every other state - facing a budget shortfall. We are hopeful that the Strategic Planning team's action plan will recognize that there are things that can be done in the short term which do not require substantial state expenditures, and that it is still desirable to plan for the time when state revenues will rebound.

Given the present economic uncertainty, it is not very likely that the coverage expansion proposals will be undertaken in full in the near future. However, the prospect appears quite good for moving forward with some proposals that do not require major legislative action or expenditures.

SECTION 6. LESSONS LEARNED AND RECOMMENDATIONS TO STATES

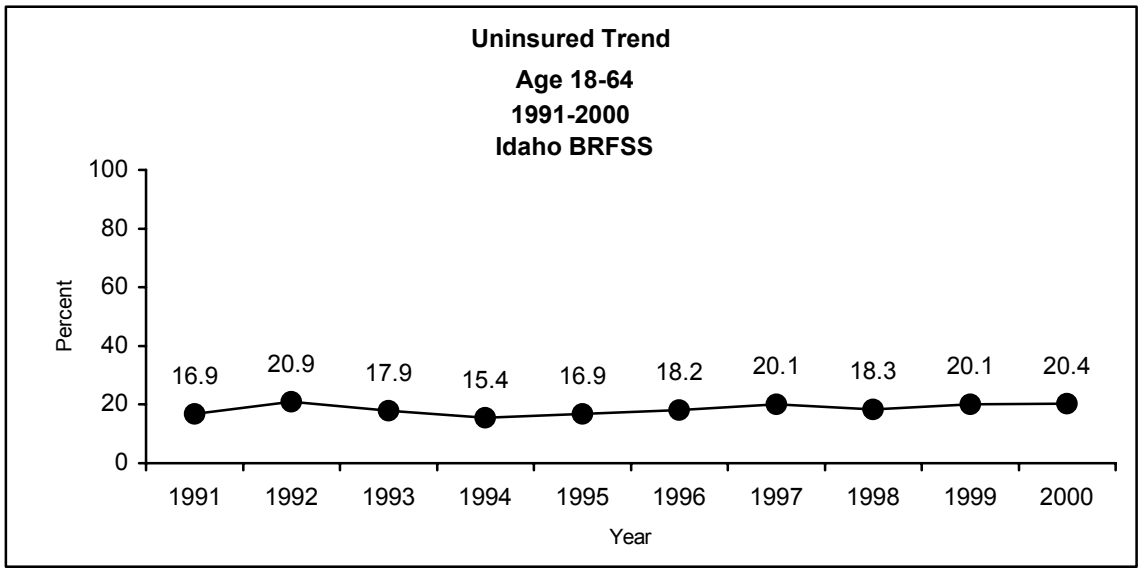
SECTION 7. RECOMMENDATIONS TO THE FEDERAL GOVERNMENT

APPENDIX: BASELINE INFORMATION

Population: Idaho's total population (2000 Census) is 1,293,953.

Number and percentage of uninsured (current and trend):

Approximately 18%, or 200,000 – 240,000 Idahoans currently lack health insurance (1997-1999 CPS, 2000 BRFSS). The trend for being uninsured (among ages 18-64) has remained relatively stable since 1991.



Average age of population: Idaho's median age (2000 Census) is 33.2 years of age.

Percent of population living in poverty: The estimated percent of people of all ages in poverty for Idaho is 12.6% (US Census Bureau, State Estimates for People of All Ages in Poverty for US: 1998, released August 2001).

Primary industries:

Industry	Total Employment, 1999
Services	199,264
Retail Trade	131,003
State & Local Government	88,442
Manufacturing	82,201
Construction	54,408
Finance, Insurance & Real Estate	50,150
Farm	39,381

Industry	Total Employment, 1999
Wholesale Trade	34,995
Transport, Comm., & Public Utilities	33,040
Ag Services, Forestry, Fishery, & Other	17,198
Federal Civilian	12,666
Federal Military	9,718
Mining	3,261

Idaho Department of Commerce, Idaho State Profile, Pub #IDC 01 33120, http://www.idoc.state.id.us/idcomm/cntypro.html

Number and percent of employers offering coverage:

From the Idaho Employer Health Care Benefit Survey, about half of respondents (48.5%) reported offering health benefits and/or a health plan to their employees. This equates to approximately 25,000 of Idaho's 52,000 businesses (excluding government agencies and most schools).

Number and percent of self-insured firms:

The majority (82.2%) of respondents are fully-insured, 11.6% are self-insured, and 6.2% fund health care benefits using other means, usually partially self-insuring. Almost one-third (29.0%) of respondents have considered changing the funding of their health plan in the past two years. Among these, 25.3% have considered changing to fully insured benefits, 46.3% have considered changing to self-insured benefits, and 28.4% have considered changing to another type, usually partially self-insured. Based on the estimate of 11.6% of firms funding benefits self-insured, there are approximately 2,900 self-insured businesses in Idaho.

Payer mix:

Population Distribution by Insurance Status in Idaho and U.S.

Insurance Status	Percent, Idaho*	Percent, US*
Employer	56%	58%
Individual	7%	5%
Medicaid	8%	10%
Medicare	11%	11%
Uninsured	18%	16%
Total	100%	100%

* Results from 1997-1999 CPS.

Provider competition:

- From the Employer Health Care Benefit Survey, 82% of respondents fund health care benefits fully-insured. Among those, the breakdown of benefit structure is as follows:

Structure of Fully Insured Health Benefits

Benefit Structure	Percent
Health Maintenance Organization (HMO)	8.7%
Indemnity (traditional insurance product)	40.0%
Preferred Provider Organization (PPO)	44.7%
Other	3.2%

Note: Responses do not sum to 100% due to missing and multiple responses.

- Among those insured by Idaho's two major insurers, Blue Cross of Idaho and Regence Blue Shield, only 18% are covered by an HMO or PPO plan.

Insurance market reforms:

- Most private market reforms at the state level that are possible have been implemented in Idaho. They include:

  Private market reforms implemented in Idaho:
  Guaranteed issue;
  Guaranteed renewability;
  Portability;
  Pre-existing condition exclusions;
  Rate Limits;
  Risk adjustment;
  Standard benefit packages;
  Mandated benefits laws;
  Medical savings account (MSA);
  Any Willing Provider (AWP);
  High risk pool.

At this point, access to insurance is not our issue. Affordability/knowledge of accessibility is the issue.

Eligibility for existing coverage programs (Medicaid/CHIP/other):

- Idaho Medicaid serves distinct groups of, but not all, low-income Idahoans. They are:
  1. Children under age 6 and pregnant women at or below 133% of the Federal Poverty Level.
  2. Children age 6 through 19 at or below 100% of the Federal Poverty Level.
  3. Low-income families with children who qualify for Temporary Assistance for Needy Families (TAFI), at or below 30% of the Federal Poverty Level. ($4,200 for a family of 3).
  4. Supplemental Security Income recipients (aged, blind, disabled) from 79 to 138% of the FPL.
  5. Low-income nursing home residents over age 21 up to 222% of FPL.
  6. Certain low-income Medicare beneficiaries.

7. Disabled children with special health needs and children in foster care.
8. Individuals meeting the criteria for the home and community bases services waiver up to 222% of FPL.

- Idaho CHIP covers children 0-6 whose family income falls between 133 and 150% of FPL and children 7-19 whose family income falls between 100 and 150% of FPL. Coverage is available statewide.

Use of Federal waivers:
No federal waivers have been sought to expand health insurance coverage in Idaho.